

Appendix H: New Claim Form Instructions

The CMS 1500 (12/90), the UB-92, and the American Dental Association (ADA) 2002 paper forms have been revised and will be replaced with the new CMS 1500 (08/05), the UB-04, and ADA 2006 claim forms, respectively. Please review the *New Claim Form Instructions Special Bulletin*, which is available online at DMA's Web site (<http://www.ncdhhs.gov/dma/bulletin.htm>).

Samples of the new forms follow this page.

Contact EDS with any billing questions (800-688-6696 or 919-851-8888).

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 04/08

1. MEDICARE		2. MEDICAID		3. TRICARE (CHAMPUS (Formerly SSA))		4. CHAMPVA (Veteran's CM)		5. GROUP HEALTH PLAN (Self or Spouse)		6. RECA (RUCS (RUCS))		7. OTHER (RUCS)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)													
3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F)													
4. PATIENT'S ADDRESS (No., Street)													
5. PATIENT'S STATUS (Single Married Other)													
6. PATIENT'S EMPLOYMENT (Employed Full-Time Student Part-Time Student)													
7. INSURED'S NAME (Last Name, First Name, Middle Initial)													
8. INSURED'S ADDRESS (No., Street)													
9. INSURED'S POLICY GROUP OR POLICY NUMBER													
10. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F)													
11. EMPLOYER'S NAME OR SCHOOL NAME													
12. INSURANCE PLAN NAME OR PROGRAM NAME													
13. IS THERE ANY OTHER HEALTH INSURANCE PLAN? (YES NO) If yes, return to and complete item 9-a.													
14. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits which to myself or to the party which is properly responsible below.)													
15. DATE (MM DD YY)													
16. IF PATIENT HAS NAME OR NAME CHANGE, GIVE FIRST DATE (MM DD YY)													
17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM MM DD YY TO MM DD YY)													
18. OUTSIDE LAB? (YES NO) \$ CHARGES													
19. MEDICARE RESUBMISSION CASE (ORIGINAL REF. NO.)													
20. PRIOR AUTHORIZATION NUMBER													
21. DATE(S) OF SERVICE (From MM DD YY To MM DD YY)													
22. PROVIDER'S NAME, ADDRESS, OR SUPPLIES (Explain Universal Identification)													
23. DIAGNOSIS (ICD-9-CM)													
24. DATE(S) OF SERVICE (From MM DD YY To MM DD YY)													
25. PROVIDER'S NAME, ADDRESS, OR SUPPLIES (Explain Universal Identification)													
26. DATE(S) OF SERVICE (From MM DD YY To MM DD YY)													
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98. DATE(S) OF SERVICE (From MM DD YY To MM DD YY)													
99. PROVIDER'S NAME, ADDRESS, OR SUPPLIES (Explain Universal Identification)													
100. DATE(S) OF SERVICE (From MM DD YY To MM DD YY)													

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED CMB-0938-0909 FORM CMS-1500 (08-05)

Medicaid has begun accepting the new claim form. More information and the instruction manual are available online through the National Uniform Claim Committee (NUCC; www.nucc.org).

UB-04 Claim Sample

1		2		3a PAT. CNTL # b. MED. REQ. #		4 TYPE OF BILL	
5 FED. TAX NO.		6 STATEMENT COVERS PERIOD FROM		7 THROUGH			
8 PATIENT NAME		a		9 PATIENT ADDRESS		a	
b		b		c		d	
10 BIRTHDATE		11 SEX		12 DATE		13 ADMISSION 13 HR 14 TYPE 15 SRC 16 DHR 17 STAT 18 19 20 21	
22		23		24		25	
26		27		28		29 ACCT STATE 30	
31 OCCURRENCE DATE		32 OCCURRENCE CODE		33 OCCURRENCE DATE		34 OCCURRENCE CODE	
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ADA 2006 Claim Sample

ADA Dental Claim Form									
HEADER INFORMATION 1. Type of Transaction (Mark all applicable boxes) <input type="checkbox"/> Statement of Actual Services <input type="checkbox"/> Request for Predetermination/Prior Authorization <input type="checkbox"/> EPSDT/Title XIX									
2. Predetermination/Prior Authorization Number									
INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION 3. Company/Plan Name, Address, City, State, Zip Code									
OTHER COVERAGE 4. Other Dental or Medical Coverage? <input type="checkbox"/> No (Skip 5-11) <input type="checkbox"/> Yes (Complete 5-11) 5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)									
6. Date of Birth (MM/DD/CCYY) 7. Gender <input type="checkbox"/> M <input type="checkbox"/> F 8. Policyholder/Subscriber ID (SSN or ID#)									
9. Plan/Group Number 10. Patient's Relationship to Person Named in #9 <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other									
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code									
POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3) 12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
13. Date of Birth (MM/DD/CCYY) 14. Gender <input type="checkbox"/> M <input type="checkbox"/> F 15. Policyholder/Subscriber ID (SSN or ID#)									
16. Plan/Group Number 17. Employer Name									
PATIENT INFORMATION 18. Relationship to Policyholder/Subscriber in #12 Above <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent Child <input type="checkbox"/> Other 19. Student Status <input type="checkbox"/> PTS <input type="checkbox"/> PTS									
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code									
21. Date of Birth (MM/DD/CCYY) 22. Gender <input type="checkbox"/> M <input type="checkbox"/> F 23. Patient ID/Account # (Assigned by Dentist)									
RECORD OF SERVICES PROVIDED									
24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description			31. Fee
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
MISSING TEETH INFORMATION									
34. (Place an "X" on each missing tooth)									
35. Remarks									
AUTHORIZATIONS 36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim. X Patient/Guardian signature _____ Date _____ 37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity. Y Subscriber signature _____ Date _____									
ANCILLARY CLAIM/TREATMENT INFORMATION 38. Place of Treatment <input type="checkbox"/> Provider's Office <input type="checkbox"/> Hospital <input type="checkbox"/> EOP <input type="checkbox"/> Other 39. Number of Enclosures (00 to 99) Radiographs <input type="checkbox"/> Oral Intraoral <input type="checkbox"/> Models 40. Is Treatment for Orthodontics? <input type="checkbox"/> No (Skip 41-42) <input type="checkbox"/> Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY) 42. Months of Treatment Remaining 43. Replacement of Prosthesis? <input type="checkbox"/> No <input type="checkbox"/> Yes (Complete 44) 44. Date Prior Placement (MM/DD/CCYY) 45. Treatment Resulting from <input type="checkbox"/> Occupational Trauma/Injury <input type="checkbox"/> Auto accident <input type="checkbox"/> Other accident 46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State									
BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber) 48. Name, Address, City, State, Zip Code									
TREATING DENTIST AND TREATMENT LOCATION INFORMATION 49. NPI 50. License Number 51. SSN or TIN 52. Phone Number () 53. Address, City, State, Zip Code 54. NPI 55. License Number 56. Address, City, State, Zip Code 57. Phone Number () 58. Additional Provider ID									